# BODY MECHANIX

Nicole McDaniel, MPT 530 NW 23rd Street Suite 116 Portland OR 97210

Name: _____ Gender: M F Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

D.O.B. _____ Marital Status: _____

Occupation: _____ Hours per week: _____

Emergency Contact Name: _____ Phone: _____

Insurance Company: _____

ID or claim #: _____ Plan/Group #: _____

**Informed consent for physical therapy and care:**

I (we) hereby request and consent to physical therapy treatments and associated procedures on myself (or the patient named above for whom I am legally responsible) by Nicole McDaniel, a licensed physical therapist.

I have had the opportunity to discuss with the above named therapist the nature and purpose of physical therapy. I understand some occasional soreness and aches may result from treatment and may last a few days.

I do not expect the physical therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the therapist to exercise judgment in choosing procedures which she feels, based on the facts then known, are in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and, by signing below, I agree to the physical therapy. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition(s) for which I seek treatment.

_____ _____

Patient's or Authorized Person's Signature Date

**Payment:**

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred; except for situations involving accidents and treatments that require insurance claims. I (we) authorize the therapist and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered, and hereby release her of any consequence thereof.

_____ _____

Patient's or Authorized Person's Signature Date

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## PATIENT HEALTH HISTORY

NAME: _____ DATE: _____

Primary complaint: _____

_____

Pain scale: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (emergency) Dominant Hand: R L

Pain relieved by: _____

Pain increased by: _____

Do you have any other medical conditions or history of injury that are being treated by a health care practitioner? Y N If yes, please specify: _____

_____

Medications & supplements: _____

Surgical History: _____

Current sports and/or hobbies: _____ Hours per week: _____

Sports and hobbies during childhood: _____

How is your digestion? _____

Water intake per day? _____

Treatment Goals: _____

_____

_____

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## HIPAA PRIVACY PRACTICES ACKNOWLEGDMENT

Authorization for Use or Disclosure of Protected Health Information

I, _____ (print patient or guardian name), understand that under the Health Portability & Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and to consult with healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have the right to revoke or restrict this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I also understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient's or Authorized Person's Signature Date